SUNSET HILLS FAMILY CHIROPRACTIC

Massage Intake Paperwork

Name: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Occupation: _____

Who may we thank for your referral? _____

Have you Ever received a professional Massage: □ Yes □ No Last treatment: _____

What type of touch do you prefer? □ Light/Medium □ Medium/Deep □ Deep/Trigger Point

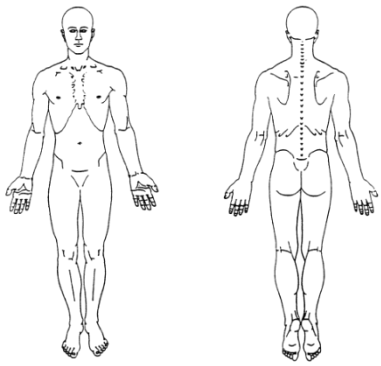
Do you have any of the following?

□ Asthma	□ Arthritis	□ Pregnancy
□ Diabetes	□ Stomach Ulcers	□ Headaches
□ Varicose Veins	□ Dizziness	□ Hernia
□ Epilepsy	□ Pacemaker	□ Cancer
□ Skin Conditions	□ Easily Bruised	□ Depression
□ High/Low Blood Pressure	□ Hemophilia	□ Phlebitis
□ Heart Disease	□ Musculoskeletal Problems	

Do you have any allergies? _____

Are there any other Health Conditions we should be aware of? □ Yes □ No
If **Yes**, please explain: _____

_____



Please mark on the chart your areas of discomfort.

What is your major complaint? _____

_____

_____

I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders – nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

Signature: _____ Date: _____